POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES

COMMUNITY HEALTH IMPROVEMENT PLAN

2016 ANNUAL REPORT

Polk County Public Health

Norman-Mahnomen Public Health

December 31, 2016

Public Health
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POLK NORMAN MAHNOMEN
community health services

Polk County Public Health www.co.polk.mn.us Norman-Mahnomen Public Health http://www.co.norman.mn.us

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Introduction

The 2015 Polk-Norman-Mahnomen Community Health Improvement Plan (CHIP) is the result of a robust Community Health Assessment process in which data was collected regarding the community health issues that are most important to Polk, Norman and Mahnomen County residents. A community-driven health improvement framework called *Mobilizing Action through Planning and Partnership (MAPP)* was used to guide the health improvement process.

The CHIP, created by community members and organizations, broadens and builds upon successful local initiatives. It is an action-oriented, living document to mobilize partners in areas where we can be most impactful on improving the health of residents, particularly those most vulnerable. The health improvement plan identifies specific evidence-based components based on community health needs (including social determinants of health).

In effort to keep the CHIP realistic and manageable, three strategic issues were chosen among partners to focus on for improvement. The resulting assignment of issues did not mean that any item is unimportant or not feasible, it only signifies what the group felt would be more serious and feasible at that time. Being able to show progress and accomplishments is important to the community leaders and sustainability of improvement projects. The group agreed that other issues/strategies may be added or removed from the plan as needed.

We recognize that by working together we can accomplish more than we could alone. The policy, systems and environmental recommendations included are designed to address our collective public health concerns, guide the implementation of the strategies proposed in this CHIP, and promote a "health in all things" approach. The purpose of the CHIP is not to create more work for our partners, but to align and leverage the efforts of multiple organizations and to move toward improved health for the residents of PNM in a strategic manner.

We are proud of our bold thinking, partnerships and action. Our CHIP is truly an example of meeting people and organizations where they are at and empowering people to contribute in ways that are personally and professionally meaningful while all working towards common goals. Due to the wide and inclusive scope, we would be remiss if we did not recognize our inability to capture every strategy that could potentially be happening across the three county region.

Process for reviewing the CHIP has included review of local data and qualitative group discussion at County Collaboratives, partner meetings/boards and 1v1 conversations from Public Health staff and directors. In context, the overall priorities have not changed, although many strategies have begun to take shape, creating an opportunity to analyze the scope and perhaps narrow the desired outcomes and/or number of priorities.

As described on the following pages, we are asset "rich" in people with passion.

Progress on CHIP Priority Areas

Decrease Persistent Poverty

How can we increase availability of living wage jobs? How can we, as a community, assure that everyone has basic resources to live in good health?

About this priority: Poverty level is one of the most critical characteristics that contribute to the number of individuals experiencing preventable chronic diseases. Decreasing persistent poverty specifically unemployment and underemployment were identified as one of the three highest priorities. Collaboration allows communities to solve problems that cannot be solved — or easily solved — by single organizations or jurisdictions. Some of the issues, such as "decreasing persistent poverty" are highly complex and generational issues. Overarching objectives include collaboration, workforce development, safe and affordable housing, transportation, childcare services and stress management (financial literacy and overall mental health).

Progress:

- The area's culture of poverty is one of the most critical factors that contribute to the number of individuals experiencing health disparities. In 2014, about 11.5% of all Minnesotans and 15% of children were in poverty. The prevalence of poverty was also higher in several counties across the state, but especially in the Northeast and Northwest regions of the state. Percent of people in poverty Polk 13%, Norman 13% and Mahnomen 26% (2014 American Community Survey 5-year estimates).
- 43% PNM population aged 25 years and older with less than or equal to high school education or equivalent (MN 33.6%) (2010-2014 ACS)
- 33% PNM people of all ages living at or below 200% of poverty (MN 26.6%) (2010-2014 ACS)
- 2014-2015 Eligible for Free/Reduced Price Lunch Polk 43%, Norman 51%, Mahnomen 78% (MN 39%)
- High school Dropout rate per 100 in 2012-2013 PNM 7.5 (MN 4.3) and four year graduation rate per 100 PNM 83 (MN 78) (MDE)(VS Trends)
- Increased organizations addressing poverty collaboratively (N=18 and growing)- Public Health, Social Services, NWMHC, Valley Community Health Center, 3rd Street Clinic, Northern Dental Access Center, Village Family Service Center, Local Food Shelves and Food Bank, Lutheran Social Services, Schools, Healthcare organizations, Salvation Army, Red Cross, Homeless Shelter, Jail, Community Action Agencies
- County Collaboratives (N=3) continue to have conversations around poverty and its impact in our counties.
- Public Health Employee Orientation- Poverty, Health Equity and Health In All Policies
- End poverty and move families toward self-sufficiency: Tri-Valley's Caring Companion Program- "Promising Practice" Award
- Tri-Valley Opportunity Council, Inc., City of Crookston, The Chamber & Visitors Bureau and the Crookston Early Childhood Initiative hosted a viewing of the "Raising of America" Documentary and open dialogue (March 2016) - poverty, early childhood development, cost and availability of childcare

- Workforce Development- Bemidji State University RN to BSN program; UMC Community Wellness and PC Wellness Coalition partnership; Crookston HS Health and Human Services Class (planned for Spring 2018)*; Health Occupations Class- Mahnomen, Fosston Schools*; Inter-County Community Council- In/Out of School Youth, Adult, Federal and State Dislocated Workers- Workforce Investment & Opportunity Act*-helping job seekers and workers access employment, education, training and support services to succeed in the labor markets; Mahnomen County Schools have had NW CEP workers* coming in 1 day/week to focus on career counselling and filling gaps that schools do not have resources to provide.
- Mahnomen County Collaborative- routinely discusses workforce and promotion of alternative career pathways and technical skills
- Minnesota Housing, Crookston Housing & Economic Development Authority (CHEDA), the City of Crookston, Tri-Valley Opportunity Council Inc, private business owners, and Otto Bremer Trust - Agassiz Townhomes in Crookston will provide affordable housing for lower income workforce, addressing a need of many employers and allowing more workers to live in the community (N=30 units)
- Safe Housing: Healthy Homes assessments (N=57, Dec 2016)/mitigation and Community/Professional Training on healthy homes (June 2016) (specifically, childhood lead exposure, radon gas exposure and mold/moisture) and hoarding; Engage NWRSDP on HIAP and safe and affordable housing; SHIP – technical assistance for HUD smoke-free multi-unit housing policy
- NWMHC: Youth Experience Success and Succeed Program; services to persons experiencing mental illness and homelessness.
- Transportation: Tri-Valley THE BUS has increased transit (8 counties including PNM)- transit access to healthcare and other community support activities, recently added bike racks, transportation for youth to a free summer meal program, Mahnomen County expanded bus service, Norman-Mahnomen now have guaranteed routes; Number of Days Served: Approximately 363 days a year; Crookston -service provided 7 days/wk; Mahnomen – service provided 5 days/wk; Ada and other cities – service provided on rural trips and usually one day per week in town. 2015 Data – 187,455 rides, 543,580.5 miles traveled, 32,892.25 hours of service; 2016 Data – 203,731 rides, 593,675 miles traveled, 34,406.75 hours of service
- Transportation: Regional Development Commission with SHIP – bike fleet award partners; SHIP Bike Crookston convener; SHIP – TA/support of new/expanded trails in PNM communities; Ada-Borup Safe Routes to School; Planning and partnership (SHIP/City/MnDOT/Tribal partners)- Highway 59 trail from Callaway to Winger-Mahnomen section of trail will be 10 ft wide
- Childcare: Tri-Valley $51,500 childcare grant* (DEED) (Applied 2016/Awarded 2017) – seek to add 140 childcare spaces (40% increase). Engage quality caregiving practices through training, technical assistance, and resources; Norman and Mahnomen counties are in cluster 1 for childcare costs (lowest in the state); Norman Co currently no waiting list for childcare assistance; Northwestern Minnesota has a licensed childcare capacity of 7,116 with a 2,623 shortfall with a critical shortage in infant care. A 37% growth in capacity is needed to fill the shortfall. A major cause of this shortfall is that the numbers and capacity of family providers has dropped by more than 25% since 2006. (MN Dept. of Human Services; U.S. Census Bureau); Quality childcare ranked third in “Community Needs” on the 2016 Tri-Valley Community Needs Assessment Survey.

- Stress Management/Poverty/Financial literacy: Multiple community based initiatives such as yoga/laughter yoga; parents helping parents support group; organic client with clinician conversations; SHIP worksite wellness collaborative topic; Schools/School readiness programs-free/reduced lunch education/enrollment; The Village Family Service Center programs-financial/stress; Tri-Valley- Four Cornerstones of Financial Literacy Training; Inter-County-Minnesota Youth Program, ages 14-24, career exploration and planning, labor market information on in-demand occupations, work readiness skills, financial literacy training and quality work experience opportunities

Successes and Challenges: It was and continues to be our goal that organizations from all sectors of the community – schools, health care providers, local government, faith organizations, service providers, and others – will actively adopt and participate in this community health plan in a way that is meaningful to their organization and its mission. The objectives have stayed relatively consistent. The strategy examples listed above have transformed over time to accommodate local needs (timing, financial and human resources, readiness, capacity) and do not include an all-inclusive list- yet it is clear that community stakeholders and partners are collaboratively working to address highly complex and often linked challenges- ultimately effecting health.

*Note: The strategies that are "Scientifically Supported- County Health Rankings" are marked with an *.*

Next Steps: Opportunity exists to engage with 1) the Northwest MN Foundation 20/20 Initiative on workforce, education and broadband, 2) Family Assets for Independence in MN (FAIM) and 3) partnerships to ensure people have basic resources to live in good health. Revisions to the CHIP will include articulating current and potential strategies and community stakeholders/partners identifying and agreeing on specific outcome indicators.

Coordination of Behavioral and Physical Health

How can we strengthen communication and coordination among health care and community partners to support healthy behaviors across the life span?

About this priority: A second priority identified was health behaviors related to the comorbidities of behavioral health and physical health. Specific "unhealthful behaviors" identified from the discussion were eating behaviors, lack of physical exercise, tobacco use, and drug abuse (legal and illegal). Individuals with a co-occurring disorder have a mortality rate 8-25 years earlier than the general population. Main objectives include coordination and integration of clinical, behavioral and complementary health services, reducing gaps in services/resources, increase understanding of preventative care and reduce stigma related to mental illness, creating an environment that makes active living and healthy foods easier and preventing alcohol, tobacco and drug use.

Progress:

- Collaborative Conversations:
  -Hospital (RiverView Health, Essentia Health Fosston, Essentia Health Ada, Altru Health N=4) Community Health Assessments- invited Public Health, Social Services, CAP agency, mental health, schools and corrections to contribute perspectives, opinions and observations.
  -Community Mental Health Mtg- Social Services/Public Health/NW Mental Health Center/Jail Admin and Nurses/Hospital- Emergency Room/Clinic

-Public Health and Essentia Health Fosston - post-partum and prenatal programs/EH Fosston and Ada- Mayo tobacco training (SHIP supported)
- Public Health (SHIP), Healthcare partners (EH Ada/Fosston, RiverView Health) and UMN Extension- Chronic Disease Management – I Can Prevent Diabetes Partnership
-Mahnomen Nutrition Network Collaborative facilitated by Lutheran Social Services- includes Tribal SHIP/SHIP, Mahnomen Food Distribution, UMN Extension, Tribal Extension, Commodity Food Distribution, SNAP, WIC, Elder/Senior Meals
-County Collaboratives, County Wellness Coalitions, Local Advisory Teams, IMPACT, Healthier Fosston, GF/EGF Tobacco Free Community Partnership, GF/EGF Safe Kids Partnership (N=12+) – individuals and organizations network/broker ideas and resources to strengthen communication/coordination among partners

- Electronic Health Information exchange- NW MN E-Health Collaborative expansion (increased number of partners)
- Social Services and Public Health- Special Needs BasicCare –Care coordination (behavioral and/or physical health)
- N=4 Medical Healthcare Homes* in PNM
- NW Mental Health Center- behavioral health co-located with primary care at EH Fosston and Ada / NWMHC recently became a behavioral healthcare home*; Provide Mental Health First Aid Training and Psychological First Aide Training; Essentia Health Ada- Wellness in the Woods/MH First Aid training event
- NAMI MN Event- 40 city tour (Oct 2016)
- Public Health/Mental Health/Probation/Law Enforcement/Fire/Ambulance (Polk/Norman)- completed Critical Incident Stress Management Course (Aug 2016)
- Essentia Health- computerized clinical decision support systems*
- PNM WIC/Family Home Visiting- focus on motivational interviewing*- client led decision making
- Public Health and Essentia Health Ada- Chronic Disease Management – I Can Prevent Diabetes Partnership (Year 1 – 7 of 9 participants completed, all 7 met or exceeded weight loss goal, Year 2- 13 enrolled); access to healthy foods: EH Ada and RiverView with SHIP/local grocers/farmers markets- Farmacy- fruit and veggie voucher
- Chronic Disease Management – I Can Prevent Diabetes – Essentia Health Fosston, RiverView Health, Altru Clinic
- Reduce gaps in services/resources: Public Health-WIC, post-partum home visits, family home visiting, breastfeeding peer support, sexual health/family planning, health promotion, tobacco cessation- referral and warm hand off/ Public Health- SHIP/HUD smoke free support and healthy homes (asthma home environment) / Healthier Fosston- enhance linkages to primary and holistic care / Norman County Resource Group (goal to increase others utilization of services)
- NWMHC practice- employee sick leave includes mental health
- Walk/Bike/Wheel- Crookston and Fosston Comprehensive Plans 2016 (streetscape design*), Fosston FIT trail, Crookston Trail Group, GIS Polk County Highway Dept, Ada Safe Routes to School, Mahnomen Trail plans; King of Trails 75 Coalition; GF/EGF MPO/Safe Kids Safe Routes to School; GF/EGF Greenway; active living at work: SHIP worksite wellness collaborative
- Access to healthy foods: University of Minnesota Crookston community garden- produce harvested from that garden are used by Sodexo food service on campus to feed students, faculty and staff – approx. 7,000 pounds of fruits and vegetables harvested

- Community Supported Agriculture: Riverside Community Garden (Crookston) – 10 plots; Twin Valley Community Garden – 20 plots; White Earth Tribal and Community College- Free Community Plots; Fisher-Climax Community Garden, EGF Community Garden, Farmer's Markets N=10; UMN Extension Food Network Link; NW Regional Sustainable Development Partnership- Sustainable Agriculture Food Systems support (policy, practices, production, affordability and marketing)
- Food Hub feasibility study (Tri-Valley, the Northwest Minnesota Foundation and Northwest Regional Sustainable Development Partnership funded) - create a food hub to make fresh, healthy, locally grown food readily available and affordable to regional institutions and residents. The project would create local, sustainable jobs, and provide new market opportunities for the region's small farmers. Next steps- purchasing plans, work with farmers, collaborate with organizations and create a non-profit organization
- Access to healthy foods: PNM WIC – 875 average monthly participation (Oct 15 – Sept 16); One Vegetable One Community; Crookston Eat United (free summer lunch meal program for youth with free bus transportation); Boys and Girls Club Mahnomen free summer lunch; EGF/GF free summer lunch for youth; PNM Home Delivered Meals/Meals on Wheels
- Breastfeeding Promotion Programs*: Norman County Breastfeeding Policy approved; Polk County Breastfeeding Coalition; PCPH and RiverView Health BF Friendly Workplace- MDH designation; PNM WIC BF Peer Support; media community education; SHIP worksite wellness collaborative/policy; CLC Training
- Pine to Prairie Drug Task Force (8 county NW MN) (2016)- 271 arrests for drug trafficking (almost double the 140 arrests that were made in 2015). Seized a large amount of drugs including 1,617 grams of meth, 102 grams of heroin, 38 grams of cocaine, 2.8 pounds of marijuana, and 537 prescription pills. The 102 grams of heroin was more than triple the 31 grams in 2015 and the 1,617 grams of meth was more than double the 663 grams seized.
- Alcohol, Tobacco and Other Drugs (ATOD): Toward Zero Death Coalition; GF/EGF Prescription and Synthetic Drug Abuse Community Meetings; Opioid Community Awareness Forums- GF/EGF, EGF High School and planning for Crookston, East Polk, Norman County and Mahnomen County; Regional Drug Task Force- community/professional/school/parent/youth training/education; Crookston tobacco retailers point of sale assessment conducted; Healthcare partners (N=5) development and implementation of prescribing policy/practice for opioids
- Regional Prevention Coordinator (13 counties)- ATOD resources, consultation and technical assistance to local coalitions/communities
- Norman-Mahnomen- IMPACT Coalition, Norman County and Mahnomen County Local Advisory Teams (SHIP and ATOD- focus on alcohol, tobacco, marijuana and prescription drugs- use, access and norms/40 developmental assets)

Successes and Challenges:

This priority has taken on a life of its own in a positive and inclusive way. In NW MN, we value and take pride in our rural narrative and want the best for our community's, partners, patients, staff, family and neighbors. The ultimate success thus far is community and healthcare partner's mindfulness of engaging in collaborative conversations and shared initiatives to strengthen communication (such as a warm referral) and coordination (such as e-health) among partners.

One success to elaborate on is a joint response among community and healthcare partners is law enforcement, drug task force, attorney's office, coroner's office opioid data; public health and wellness coalition surveillance and community awareness planning and events/media releases; law enforcement prescription drop boxes; law enforcement/EMT Narcan availability and hospital/clinic/ER opioid prescribing/monitoring policy development.

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Next Steps: Opportunities exist to learn more about Hospital Community Health Assessment updated priorities and Community Measures data as it relates to population health data across PNM. We will continue to engage in meaningful relationships and connect people/organizations. Revisions to the CHIP will include articulating current and potential strategies and community stakeholders/partners identifying and agreeing on specific outcome indicators. Due to the size and scope, further consideration is needed to determine if we should separate this section into two priorities- 1) Coordination of Behavioral and Physical Health (healthcare focused) and 2) Community Health Related to Preventable Disease.

Positive Social Connections for Youth

How can we promote and support social connection efforts and opportunities in our community?

About this priority: This priority strategic issue is a social determinant of health- meaning that a feeling of having social connections affects people's behavior, which in turn affects health outcomes.

Adverse experiences in early childhood create changes in the architecture of the brain that affect everything from physical to emotional development to the capacity of making healthy choices as adults. Over 35% of all Minnesota 8th, 9th, and 11th Graders who completed the 2013 Minnesota Student Survey reported having an ACE score of 1 or more (adverse childhood experiences). Children who grow up in safe, stable and nurturing environments with social connections are able to become strong, healthy, successful adults.

This priority issue is unique in that is focuses on a specific age group-youth. This is strategic for a number of reasons. We know that the health trajectory of an entire life are established very early on in child development. Youth are a unique population in that they are "sponge"-constantly learning new information, skills and expectations (norms) about ways of acting and living that contribute to health and their future (or not). Additionally, children (because their brain is still developing) are much likelier (than adults) to be able to establish and sustain healthy behaviors based on positive adult role modeling and education.

Overarching objectives includes social connectedness/developmental relationships among youth, school and community based resources for fostering healthy relationships, positive mental health, socially connected schools and increasing health related self-efficacy.

Progress:

- Social connectedness- Community Education/Park N Rec/School Districts/Activities Director- support and promote extracurricular activities and afterschool programs; Norman County Shock and Awe- High school philanthropists addressing the changing needs of our community in an innovative society; North Star Summer Program- 10-week therapeutic skills-building program to

increase the overall social functioning of children PNM locations N=8; Natural Play Space- SHIP/City/NWRSDP- intergenerational; Tribal/UMN Extension/ Mahnomen Boys and Girls Club/4-H/Dekko/Faith-based youth programming.

- School Based Interventions (safe/socially connected schools)- NWMHC School Based Mental Health services* (co-located or access to professionals as needed); Positive Behavior Interventions and Supports* – ex. Mahnomen School/Waubun School (evidence-based behavioral interventions that enhances academic and social behavior outcomes); DARE program; School Nurses; Internet Safety classes
- Public Health –Wellness Coordinator completed the ACE Interface Training (curriculum from original researcher), Public Health ACES Community Facilitator and Local Content Experts (NWMHC) have provided ACES/Trauma Informed Care Trainings- ex. Crookston Highland School, Polk County Public Health, Norman County Social Services, Tribal College (Community Training/CEU's available)
- Community awareness: Educate and advocate partners/coalitions on co-morbidities of mental health (spectrum of wellness) and physical health (health in all policies/health disparities)
- Individual, parent and family – knowledge, skills and self-esteem based support*- NWMHC group/family/individual therapy; PNM Nurse Family Partnership*N = 39 (2016)/Family Home Visiting, Breastfeeding Peer Support*, Gala for Girls (positive role models/multiple orgs involved); Tri-Valley Head Start, Early Head Start and Migrant and Seasonal Head Start; Inter-County Head Start; Early Childhood programs, school readiness, Early Childhood Special Educators, Help Me Grow, Follow Along Program, Developmental, Social-Emotional and Depression Screeners
- Connect people to resources- Norman and Mahnomen County Collaboratives- added healthcare partners; IMPACT Coalition- asset mapping- sphere of influence/community resources scan; Norman County Resource Group and Website; Planned Polk County and Mahnomen County Resource Group and Website

Successes and Challenges:

We are mindful that positive social connections for youth cannot be taken for granted and recognize critical components that should be cultivated throughout the lifespan. Most people instinctively think about mental illness when they hear "mental health". Partners have engaged in formal and informal conversations of the term "mental well-being" to understand the full, broad scope its intended. In its most basic form, partners can related to the Minnesota Public Health Mental Well-Being Advisory Group (Sept 2016) concept that "*Everyone deserves opportunity for Mental Health and Well-Being*". Further, to have a sense of self-worth, positive relationships, resilience, hopefulness and a sense of community and social contribution. As such, well-being including positive social connections for youth requires a sense of purpose and power. Partners are working autonomously and with partners to build resilience and skills to manage stress, find balance and focus, and engage socially among youth- and adults. We are frequently reminded about the power of "1". Every youth needs at least one positive adult role model in their life.

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Next Steps: Revisions to the CHIP will include articulating current and potential strategies and refining process and outcome indicators.

Next Steps Summary

Formally bring community stakeholders and partners together to reexamine priorities and strategies in June and December 2017.

More explicitly define outcome indicators and a tracking system that is mutually agreed upon by the partners.